



**Wonca**

World family doctors. Caring for people.

**Policy on  
Female Family Physicians in Rural Practice**

**2003**

Wonca Working Party on Rural Practice

World Organisation of Family Doctors

rural health

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## **POLICY ON FEMALE FAMILY PHYSICIANS IN RURAL PRACTICE**

Endorsed by  
Wonca, November 2003

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## **1. Key Objectives**

- To support women working in rural and remote family medical practice
- To increase the number of female doctors working in rural and remote family practice
- To ensure that female rural and remote doctors have equitable input into the development of policy and programmes affecting the rural medical workforce

## **2. Chapeau**

This document has been developed following extensive consultation with female rural doctors and medical students from developed countries. It is recognised that the next stage of development has to include a consultative process with female doctors from the developing world, particularly Africa, Asia and South America. This process will require a communication process specifically designed to bring forth the views and experiences of women who may be working in environments without ready access to email, fax and other ready means of communication.

## **3. Strategies**

### 3.1 Recruitment

- 3.1.1 Attract rural women into medicine
- 3.1.2 Attract women into rural medicine
- 3.1.3 Provide female medical students with rural experience
- 3.1.4 Provide female and male medical students and post-graduate trainees with female rural doctors as mentors
- 3.1.5 Teach about gender issues for rural doctors
- 3.1.6 Recruit rural women to leadership positions

### 3.2 Training

- 3.2.1 Provide accessible appropriate skills training for rural practice
- 3.2.2 Encourage surgical and procedural skills
- 3.2.3 Provide flexible and accessible continuing medical education
- 3.2.4 Provide a safe learning environment
- 3.2.5 Work with rural female trainers
- 3.2.6 Embed the teaching of gender skills as core curriculum
- 3.2.7 Develop and implement curriculum for re-entry training for doctors who have taken time out from professional practice
- 3.2.8 Develop and implement curriculum for undergraduate and post-graduate teaching in cultural safety and competency
- 3.2.9 Provide support and assistance for part-time practice and workforce re-entry

- 3.2.10 Provide training in management, leadership, negotiating skills and information technology
- 3.2.11 Ensure that child care and family friendly arrangements are made for continuing medical education events
- 3.2.12 Provide training in methods of dealing with threatening, difficult and dangerous situations
- 3.2.13 Develop policy on continuing professional development when the practitioner is not professionally active
- 3.2.14 Undergraduate training
  - 3.2.14.1 Flexible and part-time undergraduate training so the institution rather than the individual works to find a solution to family & professional interface
  - 3.2.14.2 Encourage dialogue with students concerning rural rotations to allow sensitive integration with their lives, including number and timing of rotations, adequate housing, sufficient orientation and social integration with the community
  - 3.2.14.3 Selection of faculty to emphasise successful rural practice experience

### 3.3 Support

- 3.3.1 Ensure there is a place for the whole family
- 3.3.2 Provide support for the doctor while she cares for her community
- 3.3.3 Ensure doctors have regular leave and female locum support
- 3.3.4 Lobby for adequate and paid parental leave, equitable with the rest of society
- 3.3.5 Give priority locum support for maternity leave and family crisis
- 3.3.6 Establish a female rural doctor network
- 3.3.7 Ensure respect from and for colleagues
- 3.3.8 Develop access to health services for self and family

### 3.4 Structure of rural medical practice

- 3.4.1 Develop flexible work practices
- 3.4.2 Establish a web-based tool kit to assist with negotiation with practice and community
- 3.4.3 Ensure adequate payment for the more time-consuming clinical interactions initiated by the patients of female rural doctors
- 3.4.4 Embed systems of part-time and interrupted work
- 3.4.5 Provide transparent (contracted) working arrangements
- 3.4.6 Provide flexible on-call arrangements

- 3.4.7 Develop and implement parental leave policies
  - 3.4.8 Recognize and facilitate different work styles
  - 3.4.9 Provide child care for on-call and after hours work
  - 3.4.10 Develop a web-based tool kit for managing the professional implications of transition to parenthood
  - 3.4.11 Ensure a safe working environment
  - 3.4.12 Recognize and facilitate the work styles of women
- 3.5 Representation and leadership
- 3.5.1 Ensure equitable representation of women in rural doctor professional organisations
  - 3.5.2 Develop a search plan to recruit women into leadership positions
  - 3.5.3 Organisations to be responsible for ensuring women are included
  - 3.5.4 Ensure that women are present at national and international conferences
  - 3.5.5 Ensure that women are supported to undertake scientific research
  - 3.5.6 Ensure equitable representation of women as main authors in professional publications

These strategies have been drawn from international work carried out at previous Wonca Conferences and from research into the experience of female rural and remote family physicians.

## 4. Background

International organisations are now recognising that twenty-first century science will demand a twenty-first century work place where women and men from diverse regions of the world are fully and equally empowered to do their best for the world's future (Consultative Group on International Agricultural Research 1999).

After three thousand years women are beginning to take their place in the public arena and to contribute to the public discourse about truth and the proper order of the cosmos. The truth women experience is different from the truth that has dominated the public domain up until now (Belenky et al 1997, Gilligan 1982). The challenge facing all of us is to incorporate the knowledge and culture and experience of women into thought systems and knowledge structures, such as medicine.

The maldistribution of doctors has been identified as an important equity and workforce issue in many countries (Makan 1998, AMWAC 1998) that is being confounded by the changing sex ratio of the physician workforce, and the different way female and male doctors contribute to medicine.

In the developed world there has been a radical change in the sex ratio of the students studying medicine. In the year 2000 fifty six percent of first year medical students and forty five percent of the whole student body in South Africa were women (MWIA 2001) and 47.9% of doctors in their post-intern year are female (de Villiers & de Villiers 2002). Canada, the USA, South Africa and the United Kingdom report similar trends and in Australia there is an equal number of females enrolled as first year students (Birenbaum 1995, NEJM 2000, Moodley 1999, Canadian reference from Leslie Rourke). The proportion of women among medical students in the United States has increased steadily, especially over the past decade and in 1999, forty four percent of first-year medical students were women (NEJM 2000).

During the period 1983-1999, the percentage of female general practitioners in England and Wales increased from 17.4% to 31.75%. The figures are similar in Scotland and Northern Ireland where approximately one third of all unrestricted principals are female (36.1% and 29.5% respectively). This trend is likely to continue as the number of female GP registrars now accounts for over 57% of all GP registrars (Royal College of General Practitioners 2002)

According to the Association of American Medical Colleges, in 1999 there were 38,529 medical school applicants -- a 6.0 percent decrease overall from 1998; among those who were accepted, there were 8809 men (a 2.2 percent decrease) and 7412 women (a 3.5 percent increase).

The female medical workforce is growing at a much faster rate than the male medical workforce. The increased numbers of women in the medical workforce is a global trend.

This increasing female participation in the medical workforce, combined with the different work characteristics of male and female practitioners, is likely to have a substantial impact on the future supply and distribution of medical practitioners (McEwin 2001). Female medical practitioners tend to chose general practice, work part-time and practice in capital cities or major urban areas. Women also tend to leave medicine or practice at quite low



activity levels for legitimate reasons for a short time during their careers (AMWAC 1998).

In addition, there is now good evidence from Australia and other Western countries that while all doctors have a shared body of knowledge, core competencies and professional ethos, there are different preferred working styles that can be identified as favoured by women and men (Hojat, Gonnella & Xu 1995; Turner, Tippett, Raphael 1994). An Australian study, by Redman, Saltman, Straton, Young & Paul (1994) has found that women doctors are more influenced than men in their choice of speciality by the need for “the opportunity for holistic care” (86% of women compared with 58% of men).

In general, men value psychosocial aspects of health less than women do, and tend to operate more strongly from a biomedical rather than biopsychosocial paradigm. They place less emphasis on holistic care, practice less preventive medicine, deal with one problem at a time rather than the many which patients present with, do less counselling, and prefer to carry out procedures rather than deal with mental health issues. (ref) Patients are much less likely to present to male doctors with issues of interpersonal violence or sexual assault. (Wainer 1998). These different priorities are reflected in different styles of practice (AMWAC 1998) and combine with different expectations from patients (Rogers 1996).

Female medical practitioners have distinct work characteristics. Britt, Sayer, Miller et al (1999) found that by comparison with males, female general practitioners tend to have longer consultations; manage significantly higher numbers of problems per encounter; see a higher percentage of younger patients and new patients; and manage depression more often. Tolhurst (1999) found that women doctors do more counselling and work with violence and sexual assault cases. They do the mental health work of the community. A report on professional skills of rural doctors in South Africa found that female medical practitioners were statistically more likely than male doctors to perform termination of pregnancy (De Villiers & De Villiers 2002). This is important data in understanding why the presence of women as medical providers is so important to women as patients.

There has been an unacknowledged convergence between “medicine” and “male-practiced medicine”. It has taken the presence of women in sufficient numbers to begin to assert their own style to raise the possibility that there is a way to practice medicine that reflects the priorities and values of women.

## **5. Rural Workforce**

Doctors are underrepresented in rural and impoverished areas, and in Western countries female doctors are currently even less likely to go into rural practice than their male colleagues (Strasser, Kamien, Hays & Carson 1997, Doescher, Ellesbury & Hart 2000).

In the USA only 16% of rural family physicians/general practitioners are female (Doescher, Ellsburly & Hart 2000), although this is nearly 43% among the most recently graduated cohort. Female generalists in the USA are consistently less likely than males to practice in rural areas (Doescher, Ellsburly & Hart 2000). In Australia 27% of rural general practice doctors are female, although 40% of rural family physicians under the age of 35 and 60% of rural family medicine trainees are female. In the Philippines a majority of rural doctors are women. Data from other countries may compliment this evidence.

Several Australian and Canadian papers (Rourke 1996, Wainer 1998, Carson 1998, Thompson 1997) have analysed the evidence for an emerging cultural change within the rural medical workforce and Tolhurst (1997) has drawn out some of the tensions experienced by female rural doctors as they find ways to mesh their family and professional responsibilities.

The work choices of women are generally modified by the priority they place upon the development and maintenance of personal and family relationships and the requirement to balance family responsibilities with their clinical work (Strasser, Kamien, Hays & Carson 1997). An emerging finding from Canadian research suggests that once women are recruited to rural practice, they tend to stay and the average working week for a female doctor is 48 hours per week (ref from Mary).

Female practitioners tend to be the main family carers (Wainer 2001). Hence many young women favour practice styles that have more flexible working environments and generally little or no requirement for irregular working hours and on call (McEwin 2001).

Rural medicine is the point in the profession where the changes stemming from the presence of women will be felt first and most fully. Rural medicine is almost the only branch of the profession with a shortage of applicants. It needs more recruits than apply for positions, which provides room for negotiations to reshape practice.

There is a parallel between the dialogue within rural medicine and between women and medicine. Both groups (rural and women) are saying they do medicine their own way. Their way converges with the prevailing medical culture in core skills and knowledge, and differs in context and priorities.

## 6. Collecting the Evidence

Workshops at Wonca World Rural Health conferences in Durban (1997) and Kuching (1999), and at the Wonca Conference in Dublin (1998) have tested the theory that women and men practice medicine differently, and some of the implications of that. The Wonca 4<sup>th</sup> World Rural Health Conference in Calgary produced the Calgary Commitment to Women in Rural Family Medical Practice.

At the workshop in **Durban** doctors were asked to consider how to work with the strengths of women in rural practice. Participants first had to consider what those strengths might be, and they agreed that the strengths of female doctors are:

- listening
- good at teamwork and relationships with nursing staff
- understanding gynaecological problems
- value taking care of children
- oriented to primary care and prevention
- greater room for diversity
- will work for less money
- allow the men to value their feminine
- value rural life as better for family life
- female patients appreciate female doctors

Durban workshop participants put forward recommendations that were refined by a small working group, submitted to the Recommendations Committee, and presented to the whole Conference. All but the first of these recommendations are included in the Wonca Policy on Rural Practice and Rural Health (1999).

The recommendations are:

1. That women be involved in all representative bodies and involved when decisions are being made.
2. Ensure that doctors in rural areas reflect an appropriate skills and gender mix to meet the needs of their communities
3. Support be provided for female rural doctors in practising in ways which reflect their multiple roles of doctor, wife and mother including developing strategies to empower women and men in rural medicine to set their own limits to practice. This may include, but not be limited to, flexible working hours and discontinuous training.
4. That practice patterns preferred by women be adequately remunerated and acknowledged in fee structures.
5. The establishment of spouse and family networks such as the Rural Medical Family Network, education regarding rural doctor/family relationships and professional boundaries
6. That education be provided to communities on the needs of rural doctor and their

families

7. That employment opportunities be provided for doctors' spouses
8. That suitable education opportunities be provided for doctors' children or funding to facilitate education of the doctors family and to visit family members undertaking secondary or tertiary education in a distant locale
9. That there be funding to permit travel by the doctor and family for recreation and other forms of leave
10. That financial assistance with accommodation be provided for the doctor and family
11. That future international conferences on rural health be structured to ensure the participation of as wide a spectrum of rural doctors as possible, with particular regard to involving women health workers.
12. That future WONCA regional meetings and world congresses contain a strong rural component.
13. That particular attention be paid to the involvement of women in the planning, organisation and programs of conferences. A substantial amount of time should be included in conference programs to discuss gender-related issues, including but not restricted to consideration of personal, family and professional relationships for male and female physicians, and that this include presentation of issues at plenary sessions.
14. That issues in women's health be highlighted in the clinical sessions at future rural conferences.
15. That child care and programs for children of delegates be provided at all rural health meetings and conferences.
16. That WONCA develop a policy to ensure equitable representation of women doctors on all decision-making bodies.

Recommendations that women be involved in the planning and presentation of Wonca Rural Health conferences, and that women's health, and gender issues for the rural workforce, form part of the programme content for rural conferences, have been implemented at the Kuching (1999), Calgary (2000) and Melbourne (2002) Wonca Rural Health Conferences.

Doctors attending the workshop conducted in **Dublin** in 1998 (Wainer, Bryant & Strasser 1998) agreed that women and men practice medicine differently. Women know this and men tend to contest it.

**Table 1 Women and men practice medicine differently**

<b>Women</b>	<b>Men</b>	<b>All doctors</b>
Are comfortable with emotion	See more patients	Must be able to deal with bio-medical as well as biopsychosocial presentations
See a greater number of problems per consultation	Enjoy procedures	
Do more prevention	Earn more money	
Do most of the listening and counseling	Do less screening	
Direct their time better	Resent women 'not carrying the load'	
Get behind	Want to do it all	
Have main nurturing role for families		
Different style reasserts itself, despite training & payment structure		

At a preliminary workshop held in Sydney in 1998 the interactive style of female and male doctors was noted. This showed the following:

**Table 2 Interactive style of women and men**

<b>Women</b>	<b>Men</b>
clarified issues	not allowing interruptions
more readable body language	expressed opinions as facts
easier to be not paternalistic	sat back observing
selling ideas	open to other views
eye contact	more confident presence & humour

The doctors concluded that men need to be more flexible and women need to set limits, and that medical students and young doctors should be taught about this.

A workshop on designing female friendly rural medical practice was held at the Wonca 3<sup>rd</sup> World Rural Health Conference in **Kuching**. Emerging issues from that conference included

- Sustainable practice supportive of women
- Funding that recognises the way women work
- Valuing the feminine style of practice
- Women friendly models of technology
- Gender issues in rural health research
- Gender specific and sensitive indicators of well being
- The health effects of the subordinated status of women
- Bodily integrity for women as a human right
- Women's sexual health as a priority rural health issue

More work needs to be done to bring forward these issues into a policy framework and to integrate the international work on a gender perspective in medicine and the human rights context of women's health.

The Wonca 4<sup>th</sup> World Conference on Rural Health held in **Calgary** in 2000 included a plenary address about Women as Rural Doctors and developed the Calgary Commitment to Women in Rural Family Medical Practice. This reads as follows:

## **Calgary Commitment to Women in Rural Family Medical Practice**

### **Preamble**

*We, the rural health professionals of the world, meeting in Calgary at the 4<sup>th</sup> World Rural Health Conference, recognise and celebrate the special essential contribution which women in rural practice have made and continue to make to the health of their communities.*

*Based on the well-founded knowledge that the equal contribution of women to public policy is essential to secure the future of life on this planet and enhancement of the human condition, the Calgary Commitment to Women in Rural Medical Practice will make visible the work of women.*

*This is particularly important given the increasing presence of women in rural medicine, the challenges facing women in rural practice, and the inequities of commitment to and resources for these issues around the world.*

*We will recognise the diversity of women's contribution to rural health by supporting the development of practice, policy, funding and research initiatives that reflect the following principles:*

### **Principles**

- *Rural medical practice must be structured to reflect the way women experience their lives.*
- *Sustainable rural practice for women must be flexible, safe, locally developed and culturally appropriate.*
- *The promotion of women's involvement in policy development is essential to ensure the contribution of women is included.*
- *The work which women do as rural doctors, at the request of their patients, must be appropriately valued and financially rewarded.*
- *The many contributions of women to rural medical practice must be included in core medical curriculum.*
- *Women want diversity and flexibility without pressure to conform to existing professional, training and practice structures.*
- *Local teamwork and partnerships are necessary to ensure that initiatives are developed which are appropriate to the local area.*

### **Commitment**

*This Conference commends the WONCA Working Party on Rural Practice for the work done to implement recommendations from the 2<sup>nd</sup> World Rural Health Congress concerning issues identified by women. In particular, we note the inclusion of many of the recommendations in the Policy on Rural Practice and Rural Health, and women in the scientific program of conferences.*

*To continue the essential work of restructuring rural practice to attract women, this Conference commits to working towards the equal representation of women on the WONCA Working Party, conference organising committees, and other working parties developing policy on issues in rural practice.*

*In order to advance issues that have been identified by women, this Conference supports the development of a WONCA Policy on Women in Rural Practice.*

The Women in Rural Practice (WIRP) group of the Working Party on Rural Health was established as an outcome of this Commitment and its Chairperson is a member of the Working Party. The development of the Policy on Female Rural Family Physicians is part of the mandate for the working group.

## **7. Strategies**

Drawing on this previous work at Wonca rural health conferences and research on the experience of female rural family physicians, the following strategies are put forward to meet the needs of female doctors, and the need of rural communities for women to contribute to their medical care.

### **7.1 Recruitment**

Thinking at a systems level female doctors have identified the strategy of increasing the number of medical students from a rural background, linking female medical students with female rural doctors, providing undergraduate and postgraduate education and training in rural areas, and ensuring there was a career path in rural practice (Wainer 2001, McEwin 2001, White & Fergusson 2001). Australian universities and medical colleges are already putting these strategies into place through the encouragement of rural students to apply for medicine, positively selecting rural origin students into the medical course and helping them maintain their links with rural communities through the activities of rural clubs and mentor schemes that offer all first year students a rural doctor as a mentor through their course. These universities are also increasing the amount of education students undertake in rural settings and in some instances providing a substantial portion of clinical training in rural hospitals and general practice.

#### Strategies

- Attract rural women into medicine through work with rural late primary schools, secondary schools and universities to promote application and acceptance of rural-origin students into medical and health careers
- Attract women into rural medicine
- Provide female medical students with rural experience
- Provide female and male medical students and post-graduate trainees with female rural doctors as mentors
- Teaching about gender issues for rural doctors in professional life and clinical practice as core curriculum in medical undergraduate and post-graduate education.
- Recruit rural women to leadership positions
- Provide female medical students with rural experience

### **7.2 Training**

Female rural doctors have recommended that training be available part-time, that female trainees be matched with female mentors, and that training include adequate skill development in areas important to rural practice including emergency, anaesthetic, surgical and obstetric skills (Wainer 2001, White & Fergusson 2001, McEwin 2001). The women are clear about the need for a systematic and comprehensive system of professional development and support tailored to provide them with the skills, professional relationships and confidence to provide the care communities asked of them.

The system would begin by recruiting rural students into medicine and providing them with exposure to rural medicine. It would continue with the provision of post-graduate training in

rural hospitals and practice and include training in the skills rural doctors need. Professional support would be provided by continuing medical education that was accessible to women in terms of cost, travel, child care and hours. It has been suggested that some events be held during working hours to minimise disruption to families. Additional topics for continuing medical education identified by women include non-threatening training in emergency management, with child care provided; reskilling programmes for women wanting to move from part-time to full time-work or to return to work after taking a break for parenting; and negotiation and management skills.

## Strategies

- Provide accessible appropriate skills training for rural practice
- Encourage surgical and procedural skills
- Provide flexible and accessible continuing medical education
- Provide a safe learning environment
- Work with rural female trainers
- Embed the teaching of gender skills as core curriculum
- Develop and implement curriculum for re-entry training for doctors who have taken time out from professional practice
- Develop and implement curriculum for undergraduate and post-graduate teaching in cultural safety and competency
- Provide support and assistance for part-time practice and workforce re-entry
- Provide training in management, leadership, negotiating skills and information technology
- Ensure that child care and family friendly arrangements are made for continuing medical education events
- Provide training in methods of dealing with threatening, difficult and dangerous situations
- Develop policy on continuing professional development when the practitioner is not professionally active
- Undergraduate training
  - Flexible and part-time undergraduate training so the institution rather than the individual works to find a solution to family & professional interface
  - Encourage dialogue with students concerning rural rotations to allow sensitive integration with their lives, including number and timing of rotations, adequate housing, sufficient orientation and social integration with the community
  - Selection of faculty to emphasise successful rural practice experience

Gender sensitive curriculum includes teaching about the importance of research that reflects the way women experience health and illness, and the disaggregation of data by sex. Gender –specific data is data with indicators appropriate to one sex. A gender –sensitive approach recognises different treatment for women and men in the same situation, and



Gender-disaggregated research and treatment recognises that the same treatment may have different outcomes in men and women. Both sex -the biologic aspects of being female or male - and gender – the cultural roles and meanings ascribed to each sex - are determinants of health. Medical education, research and practice have all suffered from a lack of attention to gender and a limited awareness of the health effects of the sex-role stereotypes prevalent in our society.

### **7.3 Support**

Research on the changes needed to attract women to rural medicine has found one of the most important is the need to provide work for the partners of female doctors if they are to be attracted to and retained in, rural practice (Wainer 2001). Women are clear that most doctors come with families, and communities and practices wanting to attract them would do well to act on the understanding that there must be a place for everyone in the family if they are to move to a new location. This means a job for their partner, and child care and schooling for their children. Single women have different needs, related to isolation and friendship and the awkwardness some rural communities have with single professional women. Programmes are needed to support female rural doctors who come to rural practice independently of family. Rural communities can be encouraged to welcome and integrate single women into their networks and community structures.

The Australian Medical Association recommends that local community support and incentives be provided for rural doctors, their spouses and families and that this include: education for prospective rural medical practitioners about the community; opportunities for short term tenures which may be facilitated by the Commonwealth Government purchase of the house and practice, and subsequently maintained by the local community. (Australian Medical Association Position Statements: Rural and Remote Health (July 2001).

Women have identified professional and female peer support and networking as important ways to continue professional development and reduce isolation, supported by a mentoring scheme for female trainees and new recruits to rural practice

Women want to be valued for what they do. It is a recurrent theme in the research (Tolhurst 1997, McEwin 2001, Wainer 2001) that women find themselves regarded as 'not proper doctors' because their style of practice in some ways does not mimic that of men. Women want a cultural change so that when they bring a different style to rural practice it is valued and rewarded by their colleagues, practice staff and the system, reflecting the value placed on their practice by their patients.

### **Strategies**

- Ensure there is a place for the whole family
- Provide support for the doctor while she cares for her community
- Ensure doctors have regular leave and female locum support
- Lobby for adequate and paid parental leave, equitable with the rest of society
- Give priority locum support for maternity leave and family crisis
- Establish a female rural doctor network
- Ensure respect from and for colleagues

- Develop access to health services for self and family

In Australia the Royal Australian College of General Practitioners Rural Faculty is developing a resource kit for local government and communities to assist them understand and respect the family needs of rural doctors, with an initial focus on women.

#### **7.4 Structure of rural medical practice**

The continuing societal expectation that women take primary responsibility for families has a substantial impact on the way women experience and contribute to their profession of medicine. This is highlighted in those areas of practice, such as rural medicine, that require substantial on call work and are resistant to quarantining personal time.

The differences between male and female clinicians with respect to total hours worked is almost entirely due to the greater proportion of females who chose to work part-time. In 1994, 46.8% of Australian female clinicians worked part time compared with 15.3% of males. Part-time is defined by the Australian Medical Workforce Advisory Committee as being less than forty hours per week. This figure varies within medical specialities, and is an average of the hours worked by doctors in each speciality. The proportion of females working part time was highest in the 30 and early 40 year age groups coinciding with the time when there are extra family commitments. Generally, however, women who leave the workforce return over time. This highlights the need for suitable retraining opportunities to enhance skills as well as access to childcare, if required. Satisfactory arrangements in the workplace are needed to allow women (as well as some younger male clinicians) to re-enter the workforce. (AMWAC 1998, Incitti 2002)

Recent research by Moodley, Barnes and de Villiers highlighted the scarcity of women in practice partnerships and the lack of provision of maternity leave for female family physicians in South Africa.

In addition, women and men have different patterns of relationships with their careers and family life, and this will influence the way they practice medicine. Women have cyclical and interrupted careers which reflect their other productive roles as members of the community and their families, and particularly as parents. Women and men in medicine have parallel work experiences until the women have babies, at which point the women have to find other ways to work (Carr et al, 1998, Quadrio 1991, Quadrio 2001).

The Australian Medical Association recommends support for female rural doctors to practice in ways that reflect their multiple roles, including the acceptance of flexible working hours and training courses. (Australian Medical Association Position Statements: Rural and Remote Health (July 2001).

Women are seeking an increase in the flexibility of rural practice, supported by access to part-time work. They want flexible practice arrangements especially when the children are young, including flexible working hours and on call rosters, and the possibility of job sharing. They also want less commitment to after hours work, especially while their children are young (White & Fergusson 2001, Tolhurst 1997, Wainer 2001, McEwin 2001).

Research has identified that the change that most women felt was important was to be paid properly for what they do (Wainer 2001). This could be through increased fees in recognition

of the increased level of responsibility of rural practice, increased fees for the longer, more complex consultations women are often required to provide, a pap smear incentive programme, payment for being on call to offset the costs of child care, financial support to cover the costs of child care and travel when attending continuing education events, and tax deductibility of child care.

### **Strategies**

- Develop flexible work practices
- Establish a web-based tool kit to assist with negotiation with practice and community
- Ensure adequate payment for the more time-consuming clinical interactions initiated by the patients of female rural doctors
- Embed systems of part-time and interrupted work
- Provide transparent (contracted) working arrangements
- Provide flexible on-call arrangements
- Develop and implement parental leave policies
- Recognize and facilitate different work styles
- Provide child care for on-call and after hours work
- Develop a web-based tool kit for managing the professional implications of transition to parenthood
- Ensure a safe working environment
- Recognize and facilitate the work styles of women

### **7.5 Representation and leadership**

All over the world people are drawing attention to the loss to medicine arising from the under-representation of women in decision-making and other positions. The World Health Assembly passed a resolution in 1997 (WHA50.16) "Recognising the additional value that a balance of male and female staff can bring to the work of the Organization: [and] Calls for the target for representation of women in the professional categories to be increased to 50% in WHO".

- Ensure equitable representation of women in rural doctor professional organisations
- Develop a search plan to recruit women into leadership positions
- Organisations to be responsible for ensuring women are included
- Ensure that women are present at national and international conferences
- Ensure that women are supported to undertake scientific research
- Ensure equitable representation of women as main authors in professional publications

## 8. Conclusion

Physicians who want to be rural doctors enjoy multiple roles and want to have compassionate and rewarding family and personal lives. For women to thrive in rural medicine their work lives must be restructured to allow them to serve their communities while expressing their full humanity, in balance with the rest of their lives. For men, such issues are becoming increasingly important as well

There are many areas of medicine where women do not experience a sense of being highly valued, and rural medicine should not be one of them. A welcoming and embracing response from colleagues and professional organisations and communities would be very attractive to women, who have identified the competitive and hierarchical nature of other areas of medicine as one of the main attractors to family practice. Women are hungry for the experience of being valued colleagues and members of their profession. The first branch of medicine to do that, rather than grudgingly make small incremental changes, will attract women with all that they have to offer. It makes sense for rural practice and rural communities to take the lead in this, and in some ways it has.

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